CORNERTSTONE PLASTIC SURGERY

BY FREDERICK A. COVILLE, MD

Name:_____ Date:_____

What brings you to our office?_____

PAST MEDICAL HISTORY: Have you or a family member experienced any of the following?

	YOU	FAMILY	N/A		YOU	FAMILY	N/A
AIDS/HIV Positive	☐	☐	☐	Hepatitis	☐	☐	☐
Anemia	☐	☐	☐	High blood pressure	☐	☐	☐
Arthritis	☐	☐	☐	Irregular heartbeat	☐	☐	☐
Asthma	☐	☐	☐	Kidney problems	☐	☐	☐
Back problems	☐	☐	☐	Migraine headaches	☐	☐	☐
Blood clots in legs	☐	☐	☐	Anxiety disorder	☐	☐	☐
Bleeding problems	☐	☐	☐	Pneumonia	☐	☐	☐
Cancer	☐	☐	☐	Psychiatric condition	☐	☐	☐
Chest pains	☐	☐	☐	Seizures	☐	☐	☐
Diabetes	☐	☐	☐	Skin cancer	☐	☐	☐
Ear/Eye problems	☐	☐	☐	Thyroid problems	☐	☐	☐
Heart problems	☐	☐	☐	Tuberculosis	☐	☐	☐
				Transfusion	☐	☐	☐

OPERATIONS: Please list any operations and the year they were performed.

Operation:_____ Year:_____ Operation:_____ Year:_____

Operation:_____ Year:_____ Operation:_____ Year:_____

Operation:_____ Year:_____ Operation:_____ Year:_____

MEDICATIONS: Are you presently taking any of the following? (Circle)

Aspirin/Anacin	Cough medicine	Antibiotics	Phenobarbital
Bufferin	Thyroid medicine	Blood pressure meds	Blood thinners
Motrin/Ibuprofen	Hormones	Insulin/Diabetic meds	Digitalis
Opiates	Birth control	Arthritis meds	Cortisone
Dilantin	Iron	Sleeping Pills	Diet Pills

Other:_____

Do you take herbal supplements? ☐Yes ☐No If so, please list:_____

DRUGS OR SUBTANCES OF WHICH YOU ARE ALLERGIC: _____

Do you/have you used illicit drugs? ☐Yes ☐No If yes, what was it and when?_____

The failure of reporting illicit drug use can lead to complications in surgery as well as healing. Please inform the doctor of any drug use.

Have you ever had cold sores around your mouth or any Herpes-type lesions? ☐Yes ☐No

Do you currently smoke? ☐Yes ☐No If yes, how many per day?_____ How many years?_____

Have you ever smoked? ☐Yes ☐No If yes, how many per day?_____ How many years?_____

Do you drink alcohol? ☐Yes ☐No If yes, how much/how often?_____

Have you had exposure to radiation? ☐Yes ☐No Excessive sun? ☐Yes ☐No Are you in good health? ☐Yes ☐No

Do you have a problem with excessive scarring or keloid formation after being cut? ☐Yes ☐No

Do you or a family member bruise easily? ☐Yes ☐No Do you or a family member have issues with anesthesia? ☐Yes ☐No

Have you ever been diagnosed with a psychiatric condition? ☐Yes ☐No If so, please list:_____

WOMEN ONLY: Is there a chance you might be pregnant? ☐Yes ☐No Date of last menstrual period:_____

How many pregnancies have you had?_____ C-section or Vaginal?_____ How many children?_____

Any complications with pregnancies?_____

Date of last mammogram:_____ ☐Normal ☐Abnormal Specific Abnormality:_____

Please list any family history of breast cancer:_____